Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CROWN CHIROPRACTIC
2401 N ARKANSAS
LAREDO, TX 78043

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-5087-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At the time of exam Mrs. [injured worker's name] continued to suffer pain to a compensable area. In the instance that the patient continues to suffer ongoing pain to not perform range of motion would be negligent. Given this fact of ongoing pain, a range of motion exam was needed to determine appropriate MMI/IR... Texas Mutual only paid $350.00 and owes a balance of $300.00 for one range of motion area."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The claimant was injured 4/26/10. 2. The attached treatment history indicates the claimant was evaluated by Dr. Hornedo on 4/27/10, and was prescribed medication then referred for a wrist x-ray and physical therapy that date. The claimant had physical therapy on 5/3/10, 5/5/10, and 5/13/10. Also on 5/13/10 Dr. Hornedo referred the claimant to the requestor for MMI/IR. (Exhibit) 3. The requestor's examination findings were minimal at best. (See requestor's DWC-60 packet.) 4. In view of the amount and level of treatment intervention Texas Mutual argues the injury was minor. For this reason it paid the requestor for the MMI exam but not the IR exam."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2010	99456-WP	$300.00	$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 09, 2010
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 790 - THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

   Explanation of benefits dated June 30, 2010
   - CAC-214 – WORKER'S COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. THIS PAYER NOT LIABLE FOR CLAIM OR SERVICE/TREATMENT. (NOTE: TO BE USED FOR WORKERS' COMPENSATION ONLY).
   - 891 - NO ADDITIONAL PAYMENT AFTER RECONSIDERATION

Issues

1. Are there any issues of compensability with this claim?
2. Were new issues brought up that were not addressed on EOB(s) prior to MFDR?
3. Has the Maximum Medical Improvement/Impairment Rating (MMI/IR) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent on the EOB dated June 30, 2010 lists the denial reason "CAC-214 – WORKER'S COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. THIS PAYER NOT LIABLE FOR CLAIM OR SERVICE/TREATMENT. (NOTE: TO BE USED FOR WORKERS' COMPENSATION ONLY)." This denial reason is not supported by any claim history of a Plain Language Notice (PLN-11) for this injury. The denial also comes after an amount has been paid on the first EOB dated June 09, 2010 for $350.00 for same CPT code. A MFDR review of this dispute will proceed according to applicable fee guidelines.
2. The respondent stated in their response to MFDR, "In view of the amount and level of treatment intervention Texas Mutual argues the injury was minor..." According to 28 Texas Administrative Code §133.307(d)(2)(B) the carrier may not raise issues after MFDR that were not addressed on the EOBs prior to dispute. This is outlined in part (d)(2)(B) "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." The division shall not consider this issue raised by the carrier after this dispute was filed.
3. The provider billed the amount of $650.00 for CPT code 99456-WP for a MMI/IR examination. Review of the documentation supports that MMI was assigned and one body area was rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions is reviewed. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a), the MAR for a 1st musculoskeletal area IR using Range of Motion (ROM) on the wrist (upper extremity) is $300.00. Review of the submitted documentation supports a ROM testing performed on the wrist. Therefore, the combined MAR for the MMI/IR exam is $650.00.
4. The respondent has paid $350.00. Additional reimbursement of $300.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Gregory Fournerat Medical Fee Dispute Resolution Officer	November 4, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.